Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

BURIAL FUND PROVISION SUPPLEMENTAL SECURITY INCOME (SSI) RELATED

STATEMENT OF APPLICANT/ RECIPIENT OR OTHER PERSON

CASE NAME

CASE NUMBER

NAME OF APPLICANT/RECIPIENT

NAME OF PERSON MAKING STATEMENT (IF OTHER THAN ABOVE APPLICANT/RECIPIENT) | RELATIONSHIP

Understanding that this statement is for the use of the Department of Social and Health Services, I hereby certify that:

I understand that Medicaid allows certain funds to be set aside for burial.

☐ I do not have any funds set aside for burial at this time. I will report in writing if I set aside funds for burial at a future date.

☐ I do have funds set aside for burial, and the information listed below is true and complete to the best of my knowledge. I hereby designate the funds described below as being set aside for burial.

☐ _____ for myself ☐ _____ for my spouse

☐ The funds are held in a separate account.

☐ The funds are not held in a separate account. Is the balance of the account to be used for burial? ☐ Yes ☐ No

The funds are held in:

☐ Bank account; account number _____

☐ Insurance policy; policy number _____ Policy date: _____

☐ Other (specify): _____

BANK, INSURANCE COMPANY, FUNERAL PROVIDER, RELATIVE, OR FRIEND WHERE FUNDS ARE HELD:

NAME | TELEPHONE NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

NAME | TELEPHONE NUMBER

STREET ADDRESS | CITY | STATE | ZIP CODE

I understand that I must report the following to the Department of Social and Health Services:

- any use of the burial funds for some other purpose not related to burial.
- any withdrawals or borrowing from the account, policy, or fund.
- any deposits to the account or fund.
- any interest paid to me or my spouse not left to accumulate in the account.
- any purchase or gift of other life insurance, burial contracts, cash, etc.

I also understand that if any of the burial funds are used for a purpose other than burial, the total amount used may be considered available income in the month of withdrawal and may affect my eligibility.

I know that anyone who makes or causes to be made a false statement or representation of material fact in an application or for use in determining a right to payment for services under the medical program commits a crime punishable under federal law and/or state law. I affirm that all information I have given in this document is true. I have received a copy of this document.

SIGNATURE OF PERSON MAKING STATEMENT (FIRST, MIDDLE INITIAL, LAST) WRITE IN INK | DATE | TELEPHONE NUMBER